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The National Policy for Comprehensive Health of Lesbians, Gays, Bisexuals and Transgender (LGBT) and access to the Sex Reassignment Process in the Brazilian Unified Health System (SUS): progress and challenges

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Abstract *This study aimed to analyze how the Brazilian Ministry of Health (MS) is implementing the Sex Reassignment Process (SRP) in the Unified Health System (SUS), through research of public domain official documents, systematization of surgery's quantitative data and analysis of meeting reports of the LGBT Health Technical Committee (CTSLGBT) of the MS. We conducted exploratory research combining quantitative and qualitative methods, using as methodological basis the normative proposal of health programs and systems evaluation study. The study resulted in the total data calculation of sex reassignment surgeries performed by the SUS (2008-2016), which highlight no deaths and unequal regional access; and in the monitoring of the implementation of actions of the National LGBT Health Policy by a specific committee appointed by the MS. Despite considerable progress, challenges remain. Currently, the most threatening hurdle is the possibility of a setback imposed by conservative sectors from the Executive and Legislative branches. Therefore, the visibility of achievements is a decisive step toward maintaining and enhancing SRP in the SUS.*

Key words *Public policies, Transgender people, Sex reassignment procedures*

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Introduction

Transgender people, including transvestites and transsexuals, are among the most prone to prejudice, discrimination and violence[1]. They have different gender identities than those imposed by heteronormative patterns in society. They question the hegemonic logic of biological sex as a determinant of gender identity and, for this reason, as anyone fleeing from binary and dichotomous logic, they are viewed with estrangement[2].

To demonstrate this setting, data from the Reports on Homophobic Violence in Brazil (2012) of the Office of Human Rights of the Presidency of the Republic (SDH/PR) showed that, in that year, 3,084 complaints and 9,982 violations related to the LGBT population were recorded, with 4,851 Victims. Compared with 2011, victims increased by 183.19%. The hemerographic data of these reports point out that transgender people continue to be the main victims of LGBT violence and, precisely, the most serious violence, homicides and bodily injuries[3]. The accounting of these data is underestimated due to underreporting. According to Non-Governmental Organization Transgender Europe, Brazil is the country with the highest rate of transgender people homicides in the world. Between January 2008 and April 2013, there were 486 deaths, four times more than in Mexico, ranked second[4]. Therefore, from the recognition of the complexity of the social determinants of life and health[5] of transgender people, it is necessary to implement public policies that reduce stigma and contribute to the health-disease process[6].

To familiarize with studies on the transgender population, it is crucial to understand the gender analysis category. In this study, work developed by Joan Scott is used as reference. Scott states that gender is a constitutive element of social relationships, based on the differences between sexes, and is a primary form of giving meaning to power relationships[7].

Among the group of transgender people, this work will specifically focus on the health of transsexuals. Currently, the World Health Organization (WHO) defines transsexuality as a type of gender identity disorder. Transsexual men and women identify themselves with a masculinity and/or femininity different from that expected by society due to their biological sex[8], causing a "gender dysphoria", which leads these people to demand sex change through a surgical procedure[9].

According to medicine and *psy* sciences (Psychiatry, Psychology and Psychoanalysis), transsexual people are seen as beings carriers of pathology and an International Classification of Diseases (ICD) that identifies them[2]. One of the pioneers in transsexual studies was the German endocrinologist Harry Benjamin, who published the book *The Transsexual Phenomenon* (1966), which established criteria for diagnosing transsexual people, one of which is a longstanding abjection in relation to genitalia[10]. However, researchers who discuss transgender experiences from the social and human sciences and collective health question this pathologization[10], since these experiences cast doubts upon the gender norms that govern our concepts of sex and gender[9].

The assiduous demand for transgender health services had been strong at the onset of the AIDS epidemic in 1980[2]. Thirty years after the start of that epidemic, transsexuals expanded their gains in access to health services and, especially in the SUS, a procedure based on the biomedical model: the Sex Reassignment Process (SRP). Established and regulated by the MS, through Ordinances[11,12] that define the national guidelines for the process, it has ensured, since 2008, the right of transsexuals to SRP. SRP comprises a set of health care strategies involved in the process of transforming the sexual characteristics that transsexual people experience at a particular moment in their lives[11].

It is not only the establishment of guidelines for comprehensive care in the strict sense, but a set of actions necessary to ensure the right to health, circumscribed to the transition to social life in the gender, in disagreement with the gender of birth[2]. The regulation[12] of SRP in the SUS addresses a normalization that aims to rescue the principles of universal access and comprehensive care, specifically in relation to the physical and psychosocial realms involved in the process of phenotypic and social transformation that characterizes transsexuality, primarily in the context of specialized care[2].

The expanded SRP in the SUS is included in the National Lesbian, Gay, Bisexual, Transvestite and Transsexual Comprehensive Health Policy (PNSILGBT) formulated in 2011[13]. The construction of the policy followed the government guidelines expressed in the *Brazil without Homophobia* Program coordinated by SDH/PR and currently part of the National Human Rights Program. The PNSILGBT is an initiative to build more equity in the SUS and one of its objectives is to ensure access to SRP in the SUS network[13].

Advances made by the transgender population in the health area, mainly through organized LGBT movements, have been occurring through

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their demands submitted in social control settings, such as the LGBT Public Policy Conferences and the Health Councils[13]. However, transgender people feel insecure, since ordinances can be revoked at any moment by any government, and laws are necessary to ensure this whole process[2]. This is a challenge for Brazil, which has a culture rooted in conservatism coupled with recent advances of religious fundamentalism in democratic spaces, which delegitimize the agendas of the LGBT population, putting at risk the principle of a secular state[2].

Thus, this work was proposed based on this situation, characterized by transgender women and men who experience the most diverse violence[14] daily and who demand health care. We aimed to analyze how the sex reassignment process has been implemented in the SUS and its convergence with PNSILGBT, reflecting on some advances and challenges. Through qualitative-quantitative research, we searched the databases of the sex reassignment process in an open-source information system available online, and performed a documental analysis of public policies and reports of the LGBT Technical Health Committee (CTSLGBT), which monitors the implementation of PNSILGBT at the Ministry of Health.

Methodology

This study was based on exploratory research, combining quantitative and qualitative methods, based on the normative research proposal of evaluation of health systems and programs, according to Hartz[15]. The criteria and norms on which the study built on are the means that are part of the SRP and are organized in a context, namely: 1) the problematic situation in which the SRP is inserted; 2) the objective of ensuring access to SRP in the SUS network; 3) the services involved in SRP; and 4) the desired effects/outcomes. The components evaluated in the context of PNSILGBT facilitate the collection of information about the intervention studied.

The research design drew from the decision to use the complementarity of quantitative and qualitative methods. The research was conducted over seven months (December 2015 to June 2016). Firstly, a systematic reading of official documents of the field was carried out aiming at understanding and knowing the guidelines and actions carried out at Federal level on the subject covering the transgender population. The documentary research, based on secondary public domain data, included the analysis of norms regulating SRP in the SUS, the PNSILGBT, the final reports of the National Health Conferences of 2007, 2011 and 2015 and the National Conferences of Public Policies of LGBT (2008 and 2012) that were later organized in a timely manner and shown in the timeline.

The second stage was the analysis of quantitative data on sexual reassignment surgeries performed in the SUS, beginning in 2008. They were collected through the SUS Hospital Information System (SIHSUS) and tabulated in TABWIN. They established a quantified picture of SRP in the SUS since its inception. Authors acknowledge that transsexuality does not necessarily require surgical reassignment intervention in all subjects, and that SRP is much broader and not solely based on surgery. The reconceptualization proposed in the next WHO International Classification of Diseases (ICD-11) removes the categories related to transgender identity from the classification of mental disorders, recognizing that these conditions do not meet the definition requirements of Mental Disorders[16]. However, due to data availability, we opted for the analysis of this indicator.

The third stage included the documentary analysis of the twelve memoirs of the CTSLGBT Meetings, whose function was to follow the actions of PNSILGBT, which were dated from December 2011 to August 2015 and made available by the MS Department of Strategic and Participatory Management. Data collected were coded and categorized, leading to content analysis, following Bardin's methodological reference[17]. The observations that emerged from the field were compared with the strategies presented in the four axes of PNSILGBT's Operational Plan (OP), specifically in issues related to the trans population.

The study followed all the ethical precepts of research and was approved.

Results and discussion

In order to organize the systematization of the results, we opted for the presentation of data grouped in the following sections: 1) Timeline of the public policies highlighting the achievement of the right to SRP in the SUS; 2) Quantitative analysis of SRP indicators in the SUS; 3) Qualitative analysis of SRP follow-up in SUS and its major challenges.

Public policies timeline: how did transsexuals achieve the right to the sex reassignment process in the SUS?

Health policies aimed at the transgender population have been developed very recently in Brazil to provide access to rights that have been commonly denied. They arise from the process of maturation of Brazilian democracy in the late 1970s, when a number of civil society movements were formed to advocate for historically excluded groups, such as the LGBT population[6]. One of the milestones of the onset of the political struggle of homosexuals and currently involved with all the LGBT population, was constituted through the *Grupo Somos*, founded in São Paulo in 1978. Later, in 1990, the Association of Rio de Janeiro Transvestites and Liberated, establishing a transvestite movement in groups, requiring the government to meet their demands and also participating in AIDS prevention actions. At the same time, the cause of transsexual people was included in the agenda of this movement[6].

With the advent of the AIDS epidemic, particularly affecting gays and transvestites, the LGBT movement organized itself and brought to the political scene ethical principles such as solidarity, the recognition of diversity, the fight against discrimination and stigma towards HIV positive people[6]. The expansion of these civil society movements has shaped the Brazilian setting called the LGBT Movement, whose activist practices have promoted political visibility to the problems that surround them[2].

At the federal level, the debate on the health care of transsexuals has been the subject of the CTSLGBT of the MS. This group was created in 2004[18], when the Executive branch established the "*Brazil without Homophobia - Program to Combat Violence and Discrimination against GLBT and Promotion of Homosexual Citizenship*", by the SDH/PR, in order to make broad recommendations to the different government sectors in order to ensure policies, programs and actions against discrimination and, above all, to promote equal access to qualified actions for public services[19]. In health, three priority actions were signaled to the LGBT population: 1) formalization of the CTSLGBT of the Ministry of Health, with the objective of structuring a National LGBT Health Policy; 2) production of knowledge about LGBT health and 3) health professionals training to provide care to the LGBT population[19].

The CTSLGBT, which is coordinated by the Department of Support to Participatory Management and composed of representatives of the LGBT groups and technical areas of the MS, was formalized with the objective of promoting equity in health for the LGBT population, with a view to confronting inequities regarding universal access to health services and actions in the SUS[18].

An important initiative to promote universal access for transgender people in the SUS was the introduction, through the Charter of Health Users' Rights in 2006, of the right to use the social name, either in specialized services that already host transsexuals and transvestites, or in any other service of the public health network[20].

The representation of the LGBT community in the National Health Council was achieved in 2006 and gave a new meaning to the movement's activities in the processes of democratic participation in SUS[13]. The 13th National Health Conference held in 2007 included sexual orientation and gender identity in the analysis of the social determination of health. This conference was one of the milestones for the community for future advances in the health of the LGBT population[21].

In 2008, two major events were unprecedented for the LGBT population: 1) the holding of the 1st National LGBT Conference, through SDH/PR[22], promoting the discussion of LGBT issues through the theme "Human Rights and Public Policies: the way toward ensuring LGBT citizenship"; 2) Publication of Ordinance Nº 457, of August 19, when the SUS implanted the sex reassignment surgeries for female transsexuals[11,12].

Other programs and policies of the Federal Executive branch start to use LGBT agenda issues in their texts, such as the "*Mais Saúde*" (More Health) – Right of All Program (2008), which aims to reorient health policies by increasing access to quality health services and actions. It presents specific goals to promote the fight against inequities and inequalities in health, with emphasis on LGBT. In this perspective, in order to disseminate health rights, the MS recognizes that discrimination based on sexual orientation and gender identity affects the social determination of health, the process of illness and suffering due to prejudice[13]. Thus, in 2011, the MS established the PNSILGBT[13].

Access to health services and the comprehensive health of transgender people is related to factors that can be located in the individual, social and programmatic realms that increase or decrease these people's vulnerability to illness. The implementation of the PNSILGBT brings actions to enable transgender people to transit in the premises of the SUS to receive treatment for

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their health in settings that were previously unthinkable to find[13]. In order to synthesize the historical sequence of the main moments that contributed to the construction of the PNSILGBT, the illustration outlined in a timeline is shown in Figure 1.

Quantitative analysis: what do the indicators say about the sex reassignment process?

Two concomitant forces, crucial for the viability of its construction and formulation process, marked the materialization of SRP in the SUS: 1) judicialization of the demand for the regulation and financing of the sex reassignment procedure in the SUS; and 2) the institutional opening of MS for social participation in the formulation of this public policy[23]. In 2001, the Federal Public Prosecutor's Office for the inclusion of the reassignment procedures mentioned in Resolutions Nº 1842/1997 and Nº 1.652/2002 of the Federal Council of Medicine (CFM)[24,25] in the SUS procedures table. In 2010, the CFM revoked the 2002 Resolution through Resolution Nº 1.955/2010, modifying the experimental nature of the neocolpovulvoplasty procedure (sexual reassignment from man to woman)[26]. In 2004, the Ministry of Health issued Decree Nº 1.397, later revoked, which established a Working Group to discuss the inclusion of reassignment procedures in the SUS[18].

With the establishment of the CMTSLGBT in 2004, the MS was the first governmental sector to recognize the social organization of transsexuals and formally open space for the social participation of this segment in the formulation of public policies. By means of Ordinances[11,12], the MS formalized and regulated technical and ethical guidelines for SRP care in the SUS, which initially had four university hospitals qualified in the SUS network: Porto Alegre/RS, Rio de Janeiro/RJ, Goiânia/GO and São Paulo/SP. In 2013, the MS redefines and expands SRP[12] and enables, in 2014, the fifth service of Recife/PE.

The SUS, through the SRP and PNSILGBT, aims to ensure comprehensive health care to transgender people, including actions of reception and access to SUS services, from the use of the social name, access to hormone therapy and surgeries to fit the biological body in the social gender identity. Transgender care is structured by Primary Care and Specialized Care components. Primary Care is the component of the network responsible for coordinating care and for providing continuous care to the population, besides being a priority gateway of the network. Specialized care is a set of several points of care, with different technological densities. Specialized Care components in SRP include the modalities of outpatient care (clinical, pre and postoperative follow-up and hormone therapy) and hospital care (performing surgery and pre and postoperative follow-up)[11-13].

In addition to SUS-enabled hospitals, six outpatient services are available to the transgender population, in Uberlândia/MG, Curitiba/PR, João Pessoa/PB, Belém/PA and two in São Paulo/SP[12]. The sex reassignment surgical procedure and the hormonal treatment for transsexuals is performed following a long and complex evaluation process, which can be performed from the age of 21, provided that it has a specific indication and a previous two-year follow-up by the multidisciplinary team at the SRP Specialized Care Service Ambulatory, in compliance with the CFM's Resolution[12,26].

While authors of this paper agree on the idea that not every transsexual person wants to undergo sex reassignment surgery, studies show that surgical results can have a positive impact on the lives of these people. A study that evaluated the outcome of the surgical procedure, social and psychological adjustments through the follow-up of 136 transsexuals submitted to sexual reassignment, showed that 70% of the people submitted to the procedure improved their social and psychological relationships and psychiatric aspects after surgery. Data shown suggest an improved quality of life of transsexual women and men[27].

Based on this setting, we sought to quantify the number of surgeries already performed in the SUS by qualified hospitals and the number of referrals by municipalities / states. Data were collected in SIHSUS and tabulated in TABWIN from January 2008 to May 2016, as shown in Table 1. Some 320 surgical sex reassignment procedures were performed, which are included in the SRP.

Table 2 shows the number of SRP hospitalizations authorized by region of residence from January 2008 to May 2016. We verified that most users who performed the surgical procedure resided in the Southeast and South regions.

The strong unequal access to SRP in the country is illustrated in Figure 2, where it is possible to identify that there is an even greater concentration within the regions of the dwellers who had access to SRP. In the northern region, for example, the Hospitalization Authorizations (AIH)

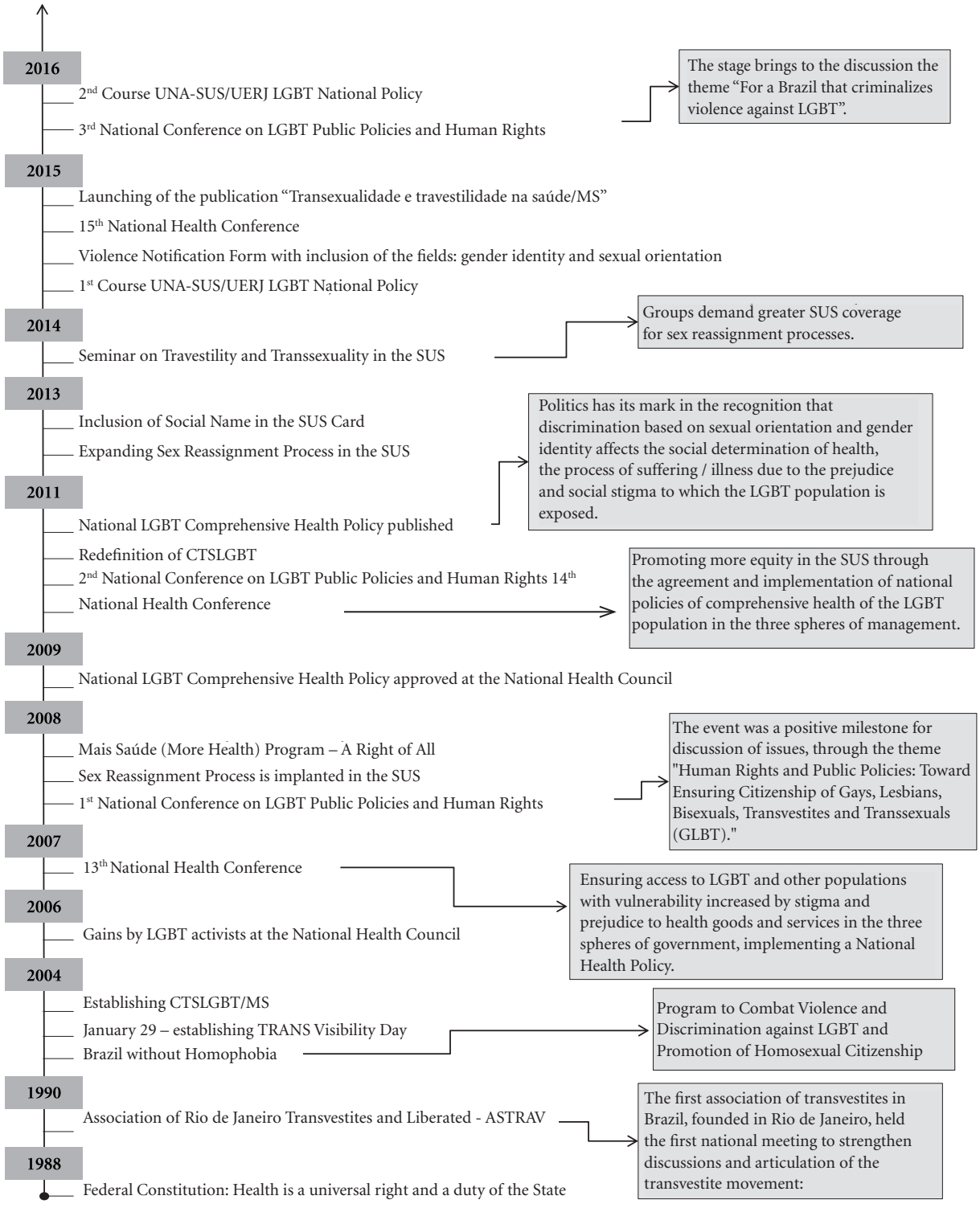

Figure 1. Some key situations that contributed to the construction of the PNSILGBT from 1988 to 2016.

Source: Authors (2016).

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registered in the SIHSUS were only of users residing in the state of Tocantins. In the Northeast, residents were from the states of Pernambuco and Bahia. Even in regions with the highest number of SRP, such as the South and Southeast, there is a concentration in States with hospitals that perform SRP.

There were no recorded deaths related to sexual reassignment procedures in the period and the average length of hospital stay ranged from 5.3 days to 9.2 days. The average expenditure on hospitalizations ranged from BRL 872.83 to 1,324.15, as shown in Table 3.

Qualitative analysis: how is the sex reassignment process monitored by the MS and what are its greatest challenges?

SRP is part of PNSILGBT, whose main objective is to promote LGBT comprehensive health, eliminating discrimination and institutional prejudice, as well as to contribute to the consolidation of the SUS as a universal, comprehensive and equitable system[6]. One of its specific objectives is to ensure access to SRP in the SUS network, according to regulated standards. The PNSILGBT provides for actions for federal, state and municipal management through its OP, which includes strategies for coping with inequities and health inequalities with a focus on the LGBT population[6].

Its operationalization builds on intra and intersectoral articulation and cross-sectional development of public policies. The OP is structured in four strategic axes and includes actions that focus on the different conditionants and determinants that sustain the social inequality in health that affects the LGBT population[13], namely: I. access of the LGBT population to comprehensive health care; II. Health promotion and surveillance actions; III. Actions and strategies for ongoing education and popular education in health; IV. Monitoring and evaluation of health actions[6].

The CMTSLGBT[18] was established to follow-up and monitor the implantation and implementation of the PNSILGBT. The qualitative analysis of the contents of the 12 reports of CTSLGBT's meetings carried out between 2011 and 2015, based on Bardin's reference method of content analysis[17] enabled reflection on the actions that the MS has been conducting to follow the implementation of the policy, specifically related SRP. The SRP in the SUS discussions were clustered around the actions planned in the PNSILGBT's OP, as described below.

Expanding comprehensive care

Drawing on data analysis, the category of expanded comprehensive care materialized based on the expanded SRP, which was repeatedly seen in the documents, appearing under different codes: "expanded care network"; "expanded services authorized for SRP"; "expanded care for

Table 2. Hospital procedures of the sex reassignment process in the SUS, by region of residence, from January 2008 to May 2016.

Region	Hospitalizations
Southeast	121
South	115
Midwest	60
Northeast	4
North	17
Federal District	3
Total	320

Table 1. Number of surgeries performed per year in hospitals authorized by the Ministry of Health to perform sex reassignment process from 2008 to 2016.

Hospital/ State	2008	2009	2010	2011	2012	2013	2014	2015	2016*	Total
HC/PE	0	0	0	0	0	0	0	9	6	15
HUPE/RJ	4	7	5	6	6	4	4	14	1	51
HC/SP	0	0	7	19	9	9	14	9	7	74
HC/RS	6	12	20	17	15	13	7	14	6	110
HC/GO	0	12	13	16	18	10	1	0	0	70
Total	10	31	45	58	48	36	26	46	20	320

*January to May.
Source: DATASUS (2016).

transgender people"; "ordinance to expand SRP in the SUS". This direction of actions and strategies aimed at expanding SRP in the SUS is corroborated by the specific objective found in the PNSILGBT[6]. The need to increase SRP in the SUS is justified in seeking universal care and expanded access to health services.

We understand that efforts directed at a specific population are necessary. However, focusing primarily on expanding specialized services for the transgender population does not guarantee their full access to health services. The first report, written in December 2011, after a redefinition of the CTSLGBT, submitted the demand for defining the gateway of transgender people in the SUS. The points of care that are presented by the MS Ordinance of 2011[28] as gateways are PHC services, urgent and emergency care, psychosocial care and special open access services. Since PHC is responsible for coordinating care and that it is where transgender people are referred to reference services, we ask ourselves whether, in fact, raising awareness so that PHC and Family Health Strategy teams are prepared to receive this population would not be important. Even with the number of transgender surgeries brought in this study and with the concern of the CTSLGBT evidenced in the documents, other recent studies have highlighted the difficulties of access of transgender people to the services of the SUS[1,4,9,10,14].

Considering the introduction of the right to the social name in the Charter of the Health Users' Rights[20] as an important action to promote universal access to the SUS, the issue of the social name as a fundamental aspect to access was also underscored. The inclusion of the social name of transgender people in the SUS card aims at recognizing the legitimacy of the identity of this population and promoting greater access to the public network. However, CTSLGBT is concerned with the use of the social name being respected by health professionals. In order to meet this de-

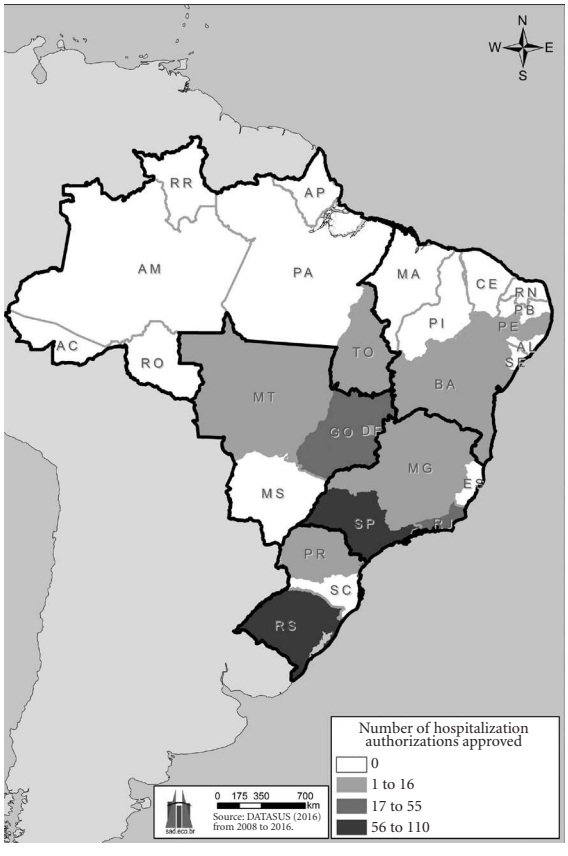

Figure 2. Hospital procedures of the sex reassignment process in the SUS, by state of residence, from January 2008 to May 2016.

Source: Authors (2016).

Table 3. Hospital procedures of the sex reassignment process in the SUS, by location of hospitalization, from January 2008 to May 2016.

Hospital/ State	Hospitalizations	Hospitalization Average Amount BRL	Stay (days)	Average stay (days)	Deaths	Mortality Rate
HC/PE	15	872.83	99	6.6	0	0
HUPE/RJ	51	1,260.71	439	8.6	0	0
HC/SP	74	1,206.93	679	9.2	0	0
HC/RS	110	1,324.15	797	7.2	0	0
HC/GO	70	865.65	374	5.3	0	0
Total	320	1,165.48	2,388	7.5	0	0

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mand, the campaign to promote respect for the use of the social name in 2013 was proposed and held. In addition, the CTSLGBT highlights:

For transgender people, an important issue is specific procedures that are performed only on the female or male sex. This gender discrimination is inadequate for transgender people; so, in addition to innovations in the SUS card, it is also necessary to adapt forms and systems to authorize specific exams and procedures (Report 12).

While the CTSLGBT gathers efforts to spread respect for the use of the social name, services do not always meet this prerogative[5], a fact also denounced by recent studies[1,4,9,10,14]. Hence, would *expanded comprehensive care* and *social name* bring transgender people closer to or keep them away from health services?

Training actions

The *training* category was a recurring present aspect in the analysis of documents. It consists of different training strategies to deal with gender, sexual orientation, race, color, ethnicity and territory discrimination and the health specificities of the LGBT population focused on the social control of health counselors, social and professional leaders and managers of health services[6].

This category was associated with the various discussions that emerged from the meetings on the need and achievements of seminars, preparation of professionals to serve the transgender people, among others. The CTSLGBT highlights the actions of ongoing education and popular education in health. Information posters were made available and distributed to all PHC facilities, with the dissemination of the right to use the social name for transgender people. There was a recommendation to make a campaign for transgender population visibility, an aspect requested by the social movement. The objective of this campaign was to promote respect and recognition of the rights of transsexuals and transvestites with a focus on health to ensure the rights of this population.

The *training* category also brings the establishment and dissemination of the course on PNSILGBT. The Open University of the Unified Health System (UNA-SUS) offered the free course, in the distance-learning modality, launched in 2015. Free access was attended by 19,427 people, with the greatest demand for professional nurses, nursing technicians and psychologists[29]. The CTSLGBT became a consultative space for social participation of the MS, counting on the representation of LGBT social movements, who from their experiences in health arenas could contribute to the construction of the contents of this course.

Through the efforts of the CTSLGBT, in 2016, the Department of Support to Participatory Management, Secretariat for Strategic and Participatory Management, the Ministry of Health launched the book *Transexualidade e Travestilidade na Saúde* ("Transsexuality and Travestility in Health"), which focused on the challenge of promoting equity in health for the transgender population[2]. In the same year, a booklet was distributed on the transgender population, geared to SUS professionals, with information on the right of all to health, free of prejudice and discrimination, also addressing guidelines on the health and reception specificities of this population.

The resources produced so far in the *training* category demonstrate that the CTSLGT fights for transgender visibility in health services and the entire population. The CTSLGBT stresses *that it is necessary to start from the basic concepts, so that people can understand and convince themselves that diversity exists and must be respected* (Report 11).

Evaluation and monitoring

This axis deals with the monitoring and evaluation of health actions for the LGBT population. As a highlight of this axis, the CMTSLGBT itself has been reformulated to continually evaluate and monitor the strategies foreseen in the axes of the PNSILGBT's OP.

The PNSILGBT monitoring and evaluation indicators are based on the morbidity and mortality and transsexual people's access to comprehensive health care through the priorities and goals of the State and Municipal Health Plans, as directed by Decree Nº 7.508/2011[28] and agreed in the Contract Organizing the Public Health Action (COAP) and Multiannual Plan (PPA) 2012-2015. Hence, from 2011, the CMTSLGBT assiduously met to plan, program and discuss the PNSILGBT and within it, SRP. Therefore, the CMTLGBT meetings themselves are a form of continuous evaluation and monitoring.

The category *evaluation*, named in the documents as "evaluate", "research" and "balance" appeared in eight of the twelve analyzed reports. Such data demonstrate that there is a predominance in the records of CTMSLGBT concerns in salvaging actions that are being carried out on SRP in all the Brazilian territory. Evaluations

carried out by the committee are also linked to future demands, as was the case of the report of meeting Nº 10, held in December 2014, in which research on the effects of hormones on the transgender population is discussed as a priority issue.

During the analysis of the 12 reports, the involvement of the committee in the actions developed and the proposals on the extended SRP was notorious. One of the concerns was the involvement of the States in the process of extending and implementing SRP, through the construction and implementation of the State LGBT Health Technical Committees.

Final considerations

Since 1988, with the implantation of SUS, we can see an advance in the health policy geared to the LGBT population. The timeline highlights the effort in gaining access to SRP and establishing the PNSILGBT. Moreover, as of 2008, the transgender population's specificities started to be partially met through outpatient clinics and SRP-enabled hospitals. The quantitative data showed that this procedure is being constantly performed, considering the number of surgeries in recent years, although there is a need for expansion throughout the country. The review of the reports of CT-SLGBT meetings shows an effort by the Ministry of Health to put the PNSILGBT axes into practice, whether by assuring access of transgender people to health, trying to establish gateways, health surveillance actions, training professionals for the qualification of care and the evaluation and monitoring of health actions. However, this is still only part of the challenge of implementing the health of transgender people, which requires practices not only geared to a pathological situation but also, above all, aimed at meeting the broader conception of health. Hence, the efforts require the involvement of social movements and social control to ensure respect for diversity within the SUS.

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Collaborations

GS Popadiuk contributed in the design of the study, in conducting research, writing and review; DC Oliveira contributed to the design of the study, the theoretical-methodological reference and the review; and MC Signorelli contributed to the design of the study, the theoretical-methodological reference and the review.

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